District Health Board

Resident Medical Officer, Dr B

A Report by the

Health and Disability Commissioner

(Case 16HDC00751)

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Executive summary

1. At 12.48am on 6 March 2016, Ms A (33 years old at the time of events) attended the Emergency Department at a public hospital with right lower quadrant abdominal pain, which she had been experiencing since the previous morning.

2. Senior House Officer Dr C ordered tests and an abdominal X-ray. Ms A was discharged at 6.19am with a prescription for pain medication and medications for constipation. Dr C documented: "Next step ? [ultrasound scan] if ongoing symptoms."

3. Later that day, at 6.27pm on 6 March 2016, Ms A re-presented to the Emergency Department. At 7.20pm, Ms A was assessed by an RMO, Dr B. Dr B documented that Ms A had re-presented with the "same pain as before". Dr B noted: "Says like labour pain. No radiation. Nothing makes better or worse."

4. Dr B ordered tests and an abdominal X-ray. The X-ray, performed 10.37pm, identified no abnormality. At 10.44pm, a registered nurse documented Ms A's pain score as four out of five. At 11.18pm, Dr B discharged Ms A after diagnosing her with constipation.

5. Ms A told HDC that she returned home and continued to experience pain and nausea. She telephoned her medical centre, and an appointment with a registered nurse was arranged for 4.30pm. Subsequently, Ms A's GP spoke with her, assessed her, and arranged an urgent referral to the Surgical Assessment Unit at the public hospital.

6. A CT scan[1] identified that Ms A had an ovarian torsion (twisted ovary), and she underwent surgery to remove the ovary.

Findings

7. Following Ms A's second presentation to the Emergency Department with a history of abdominal pain, Dr B had a responsibility to consider appropriate investigations and to discuss her presentation with a senior doctor. In addition, his diagnosis of constipation, based on the history and examinations performed, was inappropriate. Accordingly, Dr B failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

8. It was found that the errors that occurred did not indicate broader systems or organisational issues at the DHB. Accordingly, the DHB did not breach the Code directly. It was also found that the DHB took reasonably practicable steps to prevent Dr B's errors. Accordingly, the DHB was not found to be vicariously liable for Dr B's breach of the Code.

Recommendations

9. It was recommended that Dr B provide a written apology to Ms A for his breach of the Code.

[1] A CT (computed tomography) scan provides images of internal organs for diagnostic purposes.

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10. In the provisional opinion it was recommended that the DHB use an anonymised version of this case for the wider education of its medical registrars. The DHB has confirmed that it will comply with this recommendation.

Complaint and investigation

11. The Commissioner received a complaint from Ms A about the services provided to her by the DHB. The following issues were identified for investigation:

- *Whether the DHB provided Ms A with an appropriate standard of care in March 2016.*
- *Whether Dr B provided Ms A with an appropriate standard of care in March 2016.*

12. The parties directly involved in the investigation were:

Ms A	Consumer
DHB	Provider
Dr B	Provider/resident medical officer (RMO)

Also mentioned in this report:

RN D	Registered nurse

13. Information from Dr C, a house officer, was also reviewed.

14. Independent expert advice was obtained from an emergency medicine specialist, Dr Vanessa Thornton (**Appendix A**).

Information gathered during investigation

Emergency Department — initial presentation

15. At 12.48am on 6 March 2016, Ms A (33 years old at the time of events) attended the Emergency Department at the public hospital with right lower quadrant abdominal pain, which she had been experiencing since the previous morning.

16. At 1.15am, a registered nurse (RN), RN D, assessed Ms A. RN D took Ms A's vital signs and documented:

> "[Right lower quadrant] abdominal pain severe — now buckled over in pain. Previous dermoid cyst ovary. Pain started [at 10am] this morning while riding a bike. Intermittent but localised to [right lower quadrant]. Pain worsened

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throughout day and night. Vomited [once] prior to ED presentation. [No] vaginal bleeding."

17. At 2.16am, Ms A was assessed by a senior house officer, Dr C. Dr C documented that Ms A had had a bowel movement the previous day, but that Ms A "[w]ondered if it was constipation". At 2.23am, RN D documented that Ms A had a pain score of 10 out of 10.

18. Dr C ordered blood tests, including a white cell count. The test results were reported as normal, with the exception of a low potassium level. An abdominal X-ray was ordered by Dr C and performed by a radiologist who documented: "No signs of bowel obstruction."

19. Dr C prescribed Ms A paracetamol, ibuprofen, and oral morphine to relieve her pain. At 2.35am, RN D administered the medication to Ms A.

20. At 2.55am, Ms A was assessed by RN D. RN D recorded Ms A's vital signs and documented her pain score as four out of ten.

21. At 4.32am, Ms A was assessed by a registered nurse who recorded Ms A's vital signs and documented her pain score as eight out of ten.

22. Ms A was discharged at 6.19am. The discharge summary stated:

 "Discharged with [prescription] for paracetamol/ibuprofen/buscopan/laxsol. Explained unclear cause of symptoms. Given [abdominal] pain advice [and] [information] sheet on when to return. Encouraged to maintain good fluid intake. Avoid codeine/other opiates. Will follow up with GP in a few days. Next step ? [ultrasound scan] if ongoing symptoms."

23. Dr C documented on the discharge letter for Ms A that she had been reviewed by a senior medical officer, who had recommended IV fluids, IV Buscopan 40mg, and the aforementioned X-ray scan.

24. Ms A told HDC that Dr C advised her that if she was tolerating the pain she was experiencing, she could manage it at home and present to her GP on the Monday if necessary. The DHB told HDC: "It is the view of the clinicians involved that her pain was better at the time of discharge than 8/10 although it is acknowledged that she still had some pain." Dr C told HDC: "When I discharged [Ms A] I did not have the impression that her ongoing pain was of high severity. I would have strongly disagreed with discharge if that was the case."

25. The "Abdominal Pain Patient Information" sheet given to Ms A on discharge states:

 "Abdominal pain may be caused by a number of conditions. A specific cause for your pain could not be found during this visit. It is very unlikely that your pain is due to anything serious and it should go away with rest. Occasionally it is too early to make a diagnosis and significant problems are still possible … Follow up with your [general practitioner] in the next 24 hours unless completely well.

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> When to see a doctor or return to the Emergency Department:
>
> …
>
> - Vomiting; inability to keep fluids or medicine down.
>
> …
>
> - Change in pain location or worsening of pain.
> - Light-headedness or faintness."

26. Following Ms A's discharge, she continued to experience pain and nausea.

Emergency Department — second presentation

27. Later that day, at 6.27pm on 6 March 2016, Ms A re-presented to the Emergency Department.

28. At 7.07pm, Ms A was assessed by a registered nurse, and her vital signs were taken. The nurse documented that she queried Ms A's symptoms being caused by a gynaecological problem.

29. At 7.20pm, Ms A was assessed by an RMO, Dr B. Dr B documented that Ms A had re-presented with the "same pain as before". Dr B noted: "Says like labour pain. No radiation. Nothing makes better or worse. No fever, chills, chest pain, back pain. No painful urination. Normal [bowel movement] two days ago … vitals within range."

30. Dr B performed an abdominal examination and documented: "Abd[omen] soft. Suprapubic tenderness, No rebound or indirect tenderness." Dr B ordered blood tests, which showed a white cell count of 14.8, indicating a bacterial infection. The DHB told HDC: "This was a significant change from 18 hours previously."

31. At 10.37pm, an abdominal X-ray was performed. The radiologist documented in the radiology report: "The abdominal gas pattern is within normal limits. No abnormality seen." At 10.44pm, a registered nurse documented Ms A's pain score as four out of five. At 11.18pm, Dr B discharged Ms A. Dr B documented:

> "[X-ray] faecal loading, Dilates large bowel
>
> …
>
> After buscopan, paracetamol, ibuprofen and codeine still severe pain intermittently. Sevr[e]dol added. Does dampen the pain but is still having severe pain [approximately] once per hour. More generalised tenderness now. Reports not passing gas now … [Diagnosis] Constipation. Discharged home with movicol.[2] GP follow up."

32. The DHB's orientation handbook emailed to Dr B on 21 April 2015 stated under "PRE-REQUISITES FOR DISCHARGE" that a known diagnosis or the absence of a

[2] Medication to treat constipation.

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dangerous diagnosis needed to have been confirmed, and stipulated that medical practitioners in the Emergency Department needed to "beware" of undiagnosed abdominal pain.

33. The handbook also stated:

> "All patients seen between 8am and 12am will need to be discussed with the Senior Medical Officer in your zone … It is the Resident Medical Officer's responsibility to find and discuss with the SMO, not the other way around."

34. There is no record in the clinical notes of Dr B discussing Ms A's case with a senior medical officer. On the afternoon shift of Sunday 6 March 2016, two senior medical officers were working in the Emergency Department. The DHB advised that one of the medical officers was not working in the area of the Emergency Department where Ms A was seen, and the other medical officer has no recollection of Dr B discussing Ms A with her.

35. Dr B told HDC that he cannot remember with certainty any details that would explain his decision-making, beyond what was written in the notes. He also stated:

> "I am aware, as I was then, that second presentations to ED with abdominal pain are a red flag and should be discussed with a senior doctor. It was not lack of medical knowledge that caused the failure to do more detailed work up and/or keep her in the hospital.
>
> …
>
> I don't know if there was a bias that clouded my judgement. If it was fatigue. If there were any justifying details that I cannot recall. If I did talk to a senior doctor but failed to chart it."

36. The Emergency Department Clinical Director at the time of events told HDC:

> "It is my opinion that given a Consultant Emergency Physician was on duty in the department at the time and this patient had persistent significant pain and was a representation, that it would seem reasonable for [Dr B] to obtain advice from this specialist. I cannot find any evidence that this occurred."

37. Dr B told HDC that he cannot recall the details of Ms A's presentation, and cannot recall whether he discussed Ms A's case with a senior medical officer and failed to document it.

GP follow-up

38. Ms A told HDC that she returned home and continued to experience pain and nausea. She said that she took the medication provided for constipation, but was unable to have a bowel movement. On 7 March 2016, Ms A telephoned her medical centre and attempted to make an appointment with her GP but he had no appointments available. The medical centre organised an appointment for her at 4.30pm with a registered nurse.

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39. At 10.30am, Ms A presented to her medical centre and asked if she could wait for the next available appointment. Ms A was seen by a nurse, who assessed her and spoke to the GP. Subsequently, the GP spoke with Ms A, assessed her, and arranged an urgent referral to the Surgical Assessment Unit at the public hospital. Ms A said that the GP told her that they were expecting her at the Unit.

Surgical Assessment Unit

40. A CT scan[3] identified that Ms A had an ovarian torsion (twisted ovary), and she underwent surgery to remove the ovary.

Further information

41. Dr B told HDC: "I am truly sorry about the misdiagnosis and about the apparent lack of appreciation for her pain."

42. The Emergency Department Clinical Director told HDC:

> "I did not have any authority to put on any extra staff to deal with significantly increased patient numbers. For instance on the Sunday the 6th of March, there were 40 extra patients than what our average daily attendance rate is.
>
> …
>
> I think this overcrowding and intense pressure on the Emergency Department is important in the ability of medical and nursing staff to make rational and accurate decisions 24 hours a day."

43. The DHB told HDC that since this incident additional senior medical and nursing resources have been appointed. The DHB also told HDC:

> "We can assure [Ms A] that her experience has been raised with the Emergency Department medical staff to ensure the symptoms she presented with will be more carefully considered with the learning to benefit future patients attending with similar abdominal pain issues."

44. The DHB stated: "We are sorry that there was a delay in the diagnosis of [Ms A's] ovarian torsion and for the significant pain and distress she encountered in the interim."

Responses to provisional opinion

45. Ms A was provided with the "information gathered" section of the provisional opinion. She told HDC that the reason for her complaint is to raise the issue to ensure that this does not happen to someone else.

46. Dr B was provided with the relevant sections of the provisional opinion and had no further information to add.

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47. The DHB was provided with an opportunity to respond to the provisional opinion. The DHB told HDC:

> "Both our organisation and individual clinical staff of all levels of experience can learn from [Ms A's] experience to improve the care of our future patients. In December 2016, we presented an anonymised [version] of this case at the Emergency Department Mortality and Morbidity Review Meeting for patient safety and educational purposes … We will implement the Commissioner's present recommendation by sharing this case in various forums for the education of our doctors and nurses with a particular focus on those working in our emergency and gynaecology services."

Opinion: introduction

48. As a result of information and expert advice received during the investigation, this opinion focuses on the care provided to Ms A during her second presentation to the public hospital.

Opinion: Dr B — breach

49. Dr B was the RMO who assessed Ms A during her second presentation to the Emergency Department. Ms A re-presented with a history of intermittent severe abdominal pain that was not remedied by analgesia.

50. Dr B ordered further blood tests and an X-ray. He documented that the X-ray showed faecal loading and diagnosed Ms A with constipation. However, this was incorrect.

51. I note that Dr B told HDC: "I am aware, as I was then, that second presentations to ED with abdominal pain are a red flag and should be discussed with a senior doctor."

52. Expert advice was obtained from an emergency medicine specialist, Dr Vanessa Thornton. Dr Thornton stated that Dr B should have considered potential gynaecological causes for the pain, and that a CT scan should have been considered. Dr Thornton advised:

> "Diagnosis of constipation requires a history of difficult to pass hard stools which was not present in this case … The diagnosis of constipation based on the history and investigations performed was below the level of expected care for an Emergency Department registrar.
>
> …
>
> Careful consideration of the differential is required for a young woman returning with abdominal pain in the [right lower quadrant] including renal colic, gynaecological pathology and appendicitis."

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53. Dr Thornton advised that when a patient re-presents with abdominal pain, a further period of observation, discussion with a senior doctor for consideration of further investigations (such as a CT or ultrasound scan), or admission and observation is required. Dr Thornton also advised that Dr B would be expected to document any discussions he had with a senior doctor.

54. Dr B cannot recall whether he discussed Ms A's case with a senior doctor, and the senior doctor on duty cannot recall Dr B discussing Ms A's case with her. As there is no evidence that Dr B discussed the matter with a senior doctor, I find that he did not do so.

Conclusion

55. Following Ms A's second presentation to the Emergency Department with a history of abdominal pain, Dr B had a responsibility to consider appropriate investigations and to discuss her presentation with a senior doctor. In addition, his diagnosis of constipation, based on the history and examinations performed, was inappropriate. Accordingly, I find that Dr B failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: The DHB — no breach

56. As a healthcare provider, the DHB is responsible for providing services in accordance with the Code. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the DHB. Therefore, I consider that the DHB did not breach the Code directly.

57. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any actions or omissions of its employees. A defence is available to the employing authority under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

58. In March 2016, Dr B was an employee of the DHB. Accordingly, the DHB is an employing authority for the purposes of the Act. As set out above, I have found that Dr B breached Right 4(1) of the Code.

59. The DHB provided the orientation handbook emailed to Dr B on 21 April 2015. The handbook states:

> "PRE-REQUISITES FOR DISCHARGE
>
> - Known diagnosis or absence of dangerous diagnosis confirmed
>   - BEWARE: … undiagnosed abdominal pain.
>
> …

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> All patients seen between 8am and 12am will need to be discussed with the Senior Medical Officer [SMO] in your zone … It is the Resident Medical Officer's responsibility to find and discuss with the SMO, not the other way around."

60. The senior doctor who was working with Dr B has no recollection of Dr B discussing Ms A with her. There is no evidence in the clinical notes that Dr B discussed Ms A's case with a senior doctor.

61. Dr B has confirmed that he is, and was, aware "that second presentations to ED with abdominal pain are a red flag and should be discussed with a senior doctor". He stated that "[i]t was not lack of medical knowledge that caused the failure to do more detailed work up and/or keep [Ms A] in the hospital".

62. It is apparent that Dr B had been provided with the orientation handbook, which stipulates the need to "beware" of undiagnosed abdominal pain prior to discharging a patient, and the need to consult with a senior doctor. Dr B did not do so prior to discharging Ms A.

63. I note the policies that were provided to Dr B prior to the care he provided to Ms A, and that he was aware of what was expected from him in this regard. I am satisfied that the DHB took reasonably practicable steps to prevent Dr B's errors. Accordingly, I do not find the DHB vicariously liable for Dr B's breach of the Code.

Recommendations

64. I recommend that Dr B provide a written apology to Ms A for his breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

65. In the provisional opinion it was recommended that the DHB use an anonymised version of this case for the wider education of its medical registrars. The DHB has confirmed that it will comply with this recommendation.

Follow-up actions

66. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

67. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Australasian College for Emergency Medicine.

68. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from Dr Vanessa Thornton, a specialist in emergency medicine:

"I have been asked to provide an opinion to the commissioner on case number C16HDC00751, and I have read and agree to follow the commissioner's Guidelines for Independent advisors.

I am the Head of Department of Middlemore Hospital Emergency Department New Zealand, the largest Emergency Department in Australasia. I have been the HOD since 2008. My qualifications are FACEM (Fellow of the Australasian College of Emergency Medicine) and MBChB at Auckland University. I have been a fellow of the college for 16 years and graduated as a Doctor in 1992. I am drawing on my experience as an Emergency Physician and discussion with peers.

I have reviewed the following documentation:

1. Letter of complaint from [Ms A]
2. Response and clinical notes from [the DHB]

I have been advised to provide advice on the following:

Provide an opinion on the overall management of [Ms A] during both ED admissions, including but not limited to the following issues:

- The adequacy and appropriateness of the tests carried out
- The reasonableness of the diagnosis made
- The appropriateness of the discharge on these occasions

Summary of presentation

First presentation

[Ms A] self-presented to [the] Emergency Department at 0048 on the 6.3.16. She was a triage 3 and was initially in the waiting room. Her presenting complaint at triage was right iliac fossa pain (RIF). From the notes it looks like her first set of observations and nurse review was at 0223. [Ms A] described RIF pain severe in nature which started at 10am while riding a bike. The pain was intermittent but had become worse overnight and was severe at this time. She had vomited prior to presentation. She reported that she was on the pill and not pregnant. [Ms A] was buckled over at the time of presentation. The nurse reported a previous dermoid cyst. [Ms A] had taken Panadol prior to presentation.

On examination [Ms A] was lying on her side groaning with pain. Her Respiratory rate was 16 saturations 99% and was speaking two word sentences. Her blood pressure [(BP)] was 146/72 and her heart rate [(HR)] was 70.

The nurse immediately administered 10mg IV morphine at 0235 and morphine IV 5mg at 0255. At 216 she was reviewed by [Dr C] an SHO. She described onset of

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lower abo pain at 10am while riding her bike. The pain was crampy intermittent pain similar to labour pain or period pain but worse. She had never had the pain before. She reported her bowel had opened the day before but wondered if it was like constipation. The pain was intermittent and she was restless with the pain. The pain was associated with nausea and she had vomited lx. There were no urinary symptoms or vaginal discharge. Her last menstrual period was December but was on a 3 month cycle of the pill. [Ms A] had the past medical history of a dermoid cyst and had no previous surgery.

On examination [Ms A] looked in pain and was restless with the pain. Her abdomen to exam was soft and non-tender.

The impression by the house officer was abdo pain with an unclear source.

The plan from [Dr C] was analgesia and bloods and then review by a senior Dr. [Ms A] had a normal urine.

[A senior doctor] reviewed [Ms A] and suggested IV fluid, IV buscopan 40mg (2x 20mg at 0505 and 0535) and [abdominal X-ray (AXR)] to rule out obstruction.

[Ms A's] pain score was last recorded as 8/10 at 0435 and her Xray was reported as constipation by the clinicians and she was given advice on abdominal pain (in a handout), told to avoid codeine and discharged home with Panadol laxol and brufen. [Dr C] told [Ms A] that perhaps an [Ultrasound (USS)] could be considered if pain did not settle.

At 0645 a nurse has removed the IV and discharged home with an advice sheet.

Second presentation

[Ms A] represented on the 6/3/16 at 1827. She reported ongoing abdominal pain and nausea. [Ms A] was made a triage 4.

It is unclear what time the nurse made an assessment but [Ms A] described abdominal pain since 10am the day before. The pain was like contractions and she had used Panadol brufen and laxol with little effect and had ongoing vomiting and increasing pain. Her past med history included lx vaginal delivery and ovarian cyst. On examination by the nurse she had 5/5 Lower abdominal pain and had taken analgesia in waiting room.

[Ms A] was reviewed by [Dr B] (RMO) at 1920. [Dr B] had reviewed the old chart and reports a history of R sided severe abdo pain like labour lx every 10min. The pain was severe and had no radiation and there was no associated fever or sweats with this.

On examination [Ms A's] observations were HR 48 BP 130/60 pain 3/5. She was in no apparent distress and examination of her heart lungs and abdo were reported as normal.

[Dr B] reported fecal loading on x-ray and suggested paracetamol brufen IV buscopan and codeine. The pain was still severe so sevredol was added at 2030.

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A nurse review at 2125 reports that [Ms A] vomited post codeine and so IV line was placed and she was given IV ondansetron and sevredol. A urine test showed blood, protein, leucocytes and nitrates. [Dr B] said not to send urine.

A further nurse review at 2250 reports pain score of 4/5 and this was discussed with [Dr B] and he said no more pain relief at this stage.

At 2307 [Dr B] discharged [Ms A] home with a diagnosis of constipation and lax sachets and docusate.

In the notes [Ms A] returned on the 7/3 and was admitted with a torsion of the ovary and subsequently had it removed.

Response to specific questions

Provide an opinion on the overall management of [Ms A] during both ED admissions, including but not limited to the following issues:

- The adequacy and appropriateness of the tests carried out
- The reasonableness of the diagnosis made
- The appropriateness of the discharge on these occasions

I will provide opinion on each presentation separately.

First presentation

The adequacy of the tests

[Dr C] assessed and has taken a clear and concise history and completed an examination. [Dr C] ordered MSU, blood test and subsequently an AXR. These tests are at the accepted standard of care for a patient presenting for the first time to the Emergency Department with abdominal pain.

The reasonableness of the diagnosis

The diagnosis of non-specific abdominal pain is a common diagnosis in the Emergency Department and a diagnosis of exclusion thus reasonable in this case. A pelvic examination including swabs may have assisted in the diagnostic dilemma. What is important when this diagnosis is made is that very clear instructions are given to the patient at the time of discharge. In this case [Ms A] received advice about follow-up with a written handout given at the time. This is a reasonable diagnosis if the pain had settled at the time of discharge.

The appropriateness of discharge

[Ms A] had severe pain requiring 15mg of morphine. Pain requiring 15mg of morphine in a usually well patient with no real past history was not appreciated by the doctors in this case. Her pain score last recorded at 0435 was 8/10. I think that a junior doctor discharging patients with significant pain without a specific diagnosis would be a mild deviation from the standard of care expected. A period of observation to ensure resolution of pain would be the expected care. In this case

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very good discharge instructions were given and discussed with [Ms A] and she followed the advice and returned to the emergency department.

Second Presentation

The adequacy of the tests

[Ms A] returned with severe abdominal pain which was self-reported and observed by the nursing staff. Further blood tests, an x-ray and a urine were taken. The urine which showed blood, leucocytes and nitrates was not sent to the lab. The x-ray was diagnosed as constipation by the Dr which was subsequently reported as normal. Diagnosis of constipation requires a history of difficult to pass hard stools which was not present in this case.

If a patient returns with abdominal pain then there should be consideration of further investigations and discussion with a senior doctor. This is a moderate deviation from the usual standard of care for an Emergency Registrar. Given his level of experience it would be a Moderate departure from accepted standards.

The reasonableness of the diagnosis

When [Ms A] returned she had had a long period of severe intermittent pain despite regular analgesia. Consideration of a gynaecological cause would be in the differential and a pelvic exam may be considered. In ED the Registrar reported the x-ray showed constipation. This x-ray which I have not viewed was subsequently reported as a normal x-ray. The diagnosis of constipation based on the history and investigations performed was below the level of expected care (mild departure) for an Emergency Department registrar. This is on the basis that he should have discussed with the Consultant and considered further investigation and documented the discussion with the Consultant.

Careful consideration of the differential is required for a young woman returning with abdominal pain in the RIF including renal colic, gynaecological pathology and appendicitis.[1]

The appropriateness of discharge

[Ms A] was a normally fit and well patient who returned to ED with ongoing abdominal pain and nausea. [Ms A's] pain severity was 4/5 15 minutes before discharge. The history and investigations did not support constipation as a diagnosis. To discharge [Ms A] would be a moderate deviation from the expected level of care for an Emergency Registrar. A further period of observation and discussion with a senior doctor for consideration of further investigation such as a CT or USS or admission and observation is required for a patient of this nature.

The discharge of [Ms A] was a moderate deviation from the expected level of care of an emergency registrar. This is on the basis that he should have discussed [Ms A's] presentation and considered further investigations with the Senior Doctor and documented any discussions that occurred.

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General comment

The classic presentation of ovarian torsion is the acute onset of moderate to severe pelvic pain, often with nausea and possibly vomiting, in a woman with an adnexal mass.[1] However, the presentation may vary and many symptoms and signs that accompany torsion are also associated with other conditions. In addition, torsion may also occur in the absence of an adnexal mass. Thus, a high index of suspicion is required to make the diagnosis. This is of particular importance since torsion may result in the loss of ovarian function or other adverse sequelae.

A lack of appreciation of the pain that [Ms A] had experienced was evident in these presentations as [Ms A] maintained normal physiology and fundamentally normal blood tests. Further imaging would have assisted in the diagnosis of the underlying cause of [Ms A's] pain.

On the days of presentation [the Emergency Department Clinical Director] reported that there were higher than expected numbers of patients through the ED with patients in the corridors and the staff were under considerable pressure. This can impact on the ability of junior doctors to access and discuss patients with consultants in the Emergency Departments. Appreciation of pain is gained with increasing experience in emergency medicine and a diagnosis of torsion is rare (2.5% of ED presentation[1]) making suspicion and ongoing investigations more useful in this case.

[1.] Tintinelli Emergency Medicine A comprehensive study guide 6th edition"

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